Care Quality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Chelston Park Nursing and Residential Home - Chelston Gardens Dementia Nursing Home

West Buckland Road, Wellington, TA21 9PH

Tel: 01823667066

Date of Inspection: 25 November 2013

Date of Publication: December 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✗ Action needed
Management of medicines	✓ Met this standard
Complaints	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Chelston Park Nursing & Residential Home Limited
Registered Manager	Mrs. Joanne Girdler
Overview of the service	Chelston Park Nursing and Residential Home and Chelston Gardens Dementia Nursing Home are registered to provide accommodation for 86 people who require nursing and personal care. The home is situated in Wellington, Somerset.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Our inspection was unannounced and lasted approximately ten hours. We were accompanied by an expert by experience. We visited both buildings, Chelston Park Nursing and Residential Home and Chelston Gardens Dementia Nursing Home. Altogether there were 79 people living at the service; 29 people in Chelston Park and 50 people in Chelston Gardens . There is a shared registered manager and shared support services such as kitchen, laundry, training, maintenance and quality assurance across the site.

We received information of concern regarding peoples right to choose, their care and welfare and the administration of medicines. We looked at this as part of our visit. We spoke with six people living at Chelston Park Nursing and Residential Home and spent time observing those within Chelston Gardens Dementia Nursing Home. We spent time with people in communal areas of the home so we could make a judgement about how well people were cared for as some people were not able to comment directly on their care. We also spoke with twelve nursing and care staff, two housekeepers, the cook, handyman and two activities coordinators. We also spent time with both the quality assurance manager and registered manager . We looked at eleven sets of care records, and focussed on how people's consent was gained by staff. We also looked at how people's health and well-being was supported.

We found people's health and well-being was assessed, and care was provided in a way that suited people's individual needs. We saw that medicines were managed in a safe and effective way, and there was a system in place for dealing with complaints and concerns. We looked at how the provider reduced the risks of infection after we became concerned

with some infection control practices. We looked at a selection of records relating to the care people received and to the running of the home. We saw that there were areas within Chelston Park Nursing and Residential Home where care records were not always accurate and up to date.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 28 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Before people received any care or treatment in the home they were asked for their consent and the provider acted in accordance with their wishes. Within Chelston Park we heard staff discreetly asking people if they needed any help .This ranged from personal assistance; what their choices were at meal times and whether they would like to attend a musical activity in the morning and a crafts activity in the afternoon. Within Chelston Gardens, we saw staff consulting with people before care or treatment started. However, it was not always evident that the method of obtaining their choices or agreement met their individual needs. For example, staff asked people to make a choice. It was not always clear that the choices were understood. Where choices were made, we saw staff responding appropriately. This showed people were being consulted before care or treatment started and the people's views were taken into account.

The people we spoke with told us about how they chose to live in the home and how they made day to day decisions. One person told us "I like to have breakfast in my room; the staff respect my choice and offer me a choice, including a cooked breakfast". Another person said "Staff ask me what I'd like to wear each day and get my clothes ready for me". Staff we spoke with told us that some people liked to rise later in the day and had their breakfast times adjusted to allow this. This showed that people felt involved in their care and support and could make their own choices.

In several care files we saw that Do Not Resuscitate orders had been completed in conjunction with the family and GP. This showed that people and their families had been consulted about their care if medical emergencies occurred. However in one person's care files we saw a Treatment Escalation Plan (TEPs) had been completed previously but that this related to where the person used to live. The deputy manager told us that they were working with the person's doctor to ensure appropriate and current information was in place. The TEP was removed from the person's file and the deputy manager told us they would speak with the person's doctor and family members to update the information.

We saw staff supporting people appropriately. When a chiropodist visited people we saw staff ensured their treatment was provided in a private area of the home. We saw similar actions taking place when a GP visited a person. This meant the person was being treated in the way described in their care file, the patient record file and the providers Service Users Guide.

The approach to ensuring that the assessment process to check people had the capacity to make informed choices was different across the service. We saw detailed information in one person's record in Chelston Park in which a best interest decision was made on their behalf by the doctor, a member of the family and professionals involved in their care. However, this had not been undertaken for another person with a similar diagnosis. The provider may wish to note it was not clear from the care files how people's best interest were supported where they lacked capacity to make their own decisions. This was in contrast to the practice in Chelston Gardens were we saw in care records that mental capacity assessments and best interest assessments had been conducted. We saw evidence that advice had been obtained from the deprivation of liberties safeguarding assessor where concerns had been raised.

Staff we spoke with had a good understanding of consent and the mental capacity act, and had undertaken training in this. Staff said "If someone said no, I would leave them as long as they were safe. Sometimes they will consent if there is a different face or way of asking" another "I always ask, every time I do something. I can persuade but I can't insist." One relative we spoke with said "staff are kind, respectful and patient……he is listened to and makes decisions where he is able." This meant before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. In Chelston Park we looked at four people's care files and saw care plans which showed people's needs had been assessed when they moved into the home. In Chelston Gardens we looked at care files for seven people and saw detailed pre admission assessments and 'this is me' documents that had been completed with the family. We saw how this information had been used to inform the person's care plan and how care workers added to the information over time. We saw that these care plans were reviewed as people's needs changed or monthly as a routine.

The people we spoke with told us how their care was provided in ways which met their needs and that their needs were reviewed if things changed. We spent time with people, observing their care and daily routines. One person told us "The care's much better here than when I was in hospital"; whilst another person stated, "I'm well looked after and happy here". One relative we spoke with whose relative had complex care needs told us, "I'm stunned by how well he is managed".

The staff we spoke with told us how they read and updated people's care files and contributed to verbal handover reports at the change of staff shifts. Care workers told us they were kept up to date about people's changing needs by the senior nurse or deputy manager during shift handovers and at other times during the shift. We heard how care workers were informed about people's changing needs and how to meet them following a GP's visit. We saw a GP visiting a person in the home during our inspection. Information about their visit was seen to be recorded in the person's care file and prescriptions were phoned through to the local pharmacist promptly. This showed that people's needs were promptly met by informed staff.

People's choices for their daily routines were listened to and acted upon by staff. People could choose when to get up. On the day of the visit, some people were still in bed or in their rooms at lunchtime, having chosen to remain there. There was, however, encouragement to be in the dining rooms for lunch. People's independence was supported for meals and at mealtimes, and assistance was given in accordance to their planned care.

For example people with particular medical needs and dietary restrictions.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. When looking at people's files we saw that risk assessments were carried out for each person. The risk assessments showed what actions care workers should take to minimise the risks and how to support the person. For example, where a person was at risk of falling, the use of equipment was indicated. We saw the recommended equipment was available for care workers to assist that person as well as a special pressure pad to indicate the person's movement at night. Where equipment such as bed rails were required we saw that bed bumpers were provided.

We saw that care records were completed following incidents. For example where a person had fallen we saw this was noted on an accident form and in the daily notes. However, the provider may wish to note the fall was not noted on the risk assessment. This meant the impact of the fall on the person's needs might be missed from future care plan reviews. We spoke with the senior nurse about this, they arranged for the risk assessment to be updated. They told us they would add this information to the hand over sheet so staff updated records routinely in future so that the persons care and treatment would be planned to ensure their safety and welfare.

Within care records we saw evidence of multi-professional working. We saw that people had access to other health providers such as the GP, district nurse, optician, speech and language therapists and the hospital as needed.

During our inspection we saw an activity session in Chelston Park being provided by a visiting pianist and the activity co-ordinator as stated on the activity calendar. We saw how people responded positively to these activities and staff who provided them. There was an activity calendar indicating the activities for that week, as well as planned events for the Christmas period. The people we spoke with told us they enjoyed the activities which took place each week. Two people told us about how they went out on trips organised by the home. We saw photographs of previous outings framed on the reception area wall for both Chelston Park and Chelston Gardens.

Within Chelston Gardens we saw varied activities occurring. Where people were in receipt of 1:1 care, they were engaged, undertaking activities such as playing cards. Breakfast club had occurred on the ground floor of Chelston Gardens, during which people were encouraged to participate in the preparation of their breakfast. This was followed by a music quiz which was attended by approximately ten people. However, at times there were no alternatives to the planned communal activities available to people. This meant, for people who were not able to occupy themselves, there was no stimulation. We discussed this with the registered manager who informed us of a plan to increase the activities co-ordinators hours to provide cover 7 days a week.

We saw how staff were attempting to access religious support for one person whose first language was not English. Where this person needed care during the day, we saw staff found a staff member who spoke that language. We saw that the provider had obtained a written translation of common phrases; however, the provider may like to note that these were not easily accessible to either staff or the person as they were stored in the office

We checked a print out of the nurse call system to see how staff responded to people's calls for assistance. We saw the staff responded quickly to the call system with people

waiting on average one and a half minutes for support.

Staff took care to maintain privacy. Bedroom doors and curtains were closed when personal care was happening. The provider may wish to note there are some rooms on the ground floor with plate glass windows meaning passers-by could see into the rooms when, for example, people were resting in their beds as staff had not pulled the curtains during the periods of rest.

We saw various quality assurance processes were in place to monitor the service's quality and identify risks to people's welfare. These included monthly audits of both care plans and people's nutritional needs. Findings from these were fed back at staff meetings and to internal training programs. This meant that the provider was ensuring that people experienced care, treatment and support that met their needs and protected their rights.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People were not fully protected from the risk of infection because appropriate guidance had not always been followed. Some parts of the home were not completely clean or hygienic.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The people living in the home told us they were very happy with the way the home was kept. One person told us "My room is always clean and tidy and they keep it how I like it kept", whilst another person told us, "I'm happy with the way they keep my room and the home, its tidy everywhere".

We saw most parts the home had a clean and tidy appearance however in Chelston Park we saw effective systems were not in place to reduce the risk and spread of infection. For example, in a first floor bathroom/toilet we saw equipment such as a pressure relieving mattress, spare laundry bags and dirty linen wash bags draped over a bath. This meant the equipment was at risk of cross contamination as it was not stored appropriately. In all the en-suite bathrooms we looked at we saw personal protective equipment such as boxes of gloves and plastic aprons stored on low shelves next to the toilets. Hygiene wipes and clean towels were seen stored on the toilet cisterns and incontinence pads were stored loosely in the same area. All these items were at risk of cross contamination and could cause cross contamination from droplet infection.

In two of the bedrooms we looked at in Chelston Park, we saw bed rail bumpers in use which were damaged and appeared dirty. This meant the bed bumpers would not provide effective cushioning and presented a hygiene risk as they could not be cleaned effectively. In two of the cupboards we looked at which were used to store clean laundry we found linen and hoist slings stored on the floor. This meant we could not be reassured the linen and slings were clean and fit for use. We raised these concerns with the management team and they arranged for replacement bumpers to be provided and told us they would tidy the cupboards and remove items from the floor.

In the bathrooms and en-suite bathrooms we looked at we saw spray bottles indicating that the bottles contained a sanitizer. These labels did not indicate the content of the bottles or the risks posed to people. This meant the provider was not following the

guidance in relation to the control of substances hazardous to health (CoSHH) and could be placing people at risk through a lack of clear information.

Outside of the home we saw the clinical waste area was unsecured with some of the larger bins overflowing with rubbish bags stored on the floor. This meant the area was susceptible to vermin and could present a health risk. We spoke to the manager about this area; they told us this was due to their waste contractor not collecting the rubbish at the agreed period. The manager told us they would contact the contractor to arrange an urgent collection. We saw evidence that an environmental audit had been undertaken in April and May 2012, but had not been repeated this year. This meant that the provider did not have a system in place to ensure that all actions were being taken to control the spread of infections.

There was an up to date infection control policy and staff had undertaken training in infection control and hand washing. We saw gloves and aprons being used whilst staff gave personal care. Staff we spoke with understood the importance of hand hygiene.

We saw there were four cleaners on duty. They used a recognised colour coded cleaning system to help reduce the risk of cross infection. The cleaners told us about the training they received in infection control, moving and handling and health and safety. They kept daily records of the areas they cleaned and responded to spillages promptly. Effective signage was used to indicate wet floors and the signs were removed when the areas were safe to use again. Cleaning trolleys were kept in sight of the cleaner and were not left unattended. Cleaning cupboards were kept locked. This meant the cleaners operated in a way which ensured people's safety.

The kitchen which provided meals to both areas of the home had been inspected by the Food Standards Agency in August 2013 and had received a 5* rating, the highest standard the agency awards. This showed the kitchen staff maintained high standards of monitoring and cleanliness in the food preparation and cooking areas.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Appropriate arrangements were in place in relation to obtaining medicine. We saw how the deputy manager ensured people's medication was ordered in line with the homes own policy for each four week cycle. We saw that two people checked the medication was correct when it arrived in the home and saw on the medication administration record sheets (MAR) that the amounts received were clearly recorded.

During our inspection we found that appropriate arrangements were in place for the recording of medicine. We looked at the MAR sheets for the people in the home and saw that signatures were in place for all medicines administered. Where people did not need 'as required' medicines or refused their medication the relevant code was recorded on the MAR sheet. We saw that the old medication records were archived with other records in the nurses' office. There was a staff signature sheet in the front of the MAR file to help identify who had signed for the medication administered. There were currently no people managing their own medication.

When medicines were being administered we saw that medicines were handled appropriately. We saw how the person administering the medication checked the medication against the MAR sheet and the blister pack, bottle or box. The person administering put the medication into a plastic medication pot without handling the tablets. The tablets were then tipped into the persons hand or the pot was given to them. We heard how they were prompted to take their medication and saw the person being observed whilst taking their medication. Where the person was independent we saw that the medication was left with the person but that the person administering observed that the person took their tablets before assisting the next person. This meant the right person received the right medication at the right time.

Where people were given medications covertly, for example in their food, we saw there was an agreed best interest form relating to this practice. The form was completed by the nurse stating why medications were needed to be given covertly, and then signed by their GP.

Medicines were kept safely within the home. We saw that the provider had locked medication cabinets and trolleys which conformed to current guidance. The trolleys were locked and attached to the wall when not in use. The clinical room where they were stored was locked when not in use. We saw that the medication keys were kept by the senior nurse on duty.

Controlled drugs were stored and managed in accordance with current guidelines and the controlled drugs book was signed by two members of staff. This showed that one member of staff had witnessed the other staff administering and recording the controlled medicines correctly. The medication fridge was kept locked at all times and fridge temperatures were routinely monitored and recorded.

The provider may like to note we observed that some medicines commonly used in an emergency were kept within the CD cupboard. This meant that there was a risk that access to emergency medicines could be delayed due to the level of security leading to delays in the treatment of severely ill patients. In addition, whilst temperatures were recorded for the drugs fridge, these were not undertaken every day. For example records showed ten gaps in recording temperatures in October and six gaps for September.

Medicines were disposed of appropriately. The provider had suitable storage for medicines and used medication packs awaiting return. All unused or spoilt medicines were accounted for on MAR sheets and were collected and destroyed by a contractor, contracted by the pharmacist. Controlled drugs were held in the controlled drugs cabinet until the pharmacist arrived, we saw their return was signed for. This meant medication was disposed of correctly.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People were made aware of the complaints system. We saw the provider had made the complaints procedure available to all people using the service and to visitors and other professionals by pinning it to notice boards around the home. The procedure also formed part of their welcome brochure and was available on the providers' website.

The people we spoke with told us they knew how to make a complaint and felt confident that any complaint raised with the manager or their staff would be dealt with promptly. One person told us, "I've nothing to complain about, I'm happy here but I'd speak with the manager if I had concerns." whilst another person said, "I can't think of anything I could complain about but I know the staff listen to what I've got to say." This meant people were happy with the way they were listened to.

Staff we spoke with were aware of the complaints procedure and told us how they always referred concerns that they could not immediately address to the manager of deputy.

We saw evidence that the providers system for managing complaints was in line with their policy. Complaints were responded to in the agreed timescales and meetings were held with the complainant to ensure a satisfactory outcome was achieved, for example changes to the menu were made. This meant there was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because their care records were not accurate or maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's personal records including medical records were not accurate and fit for purpose. In the four care files we looked at in Chelston Park we saw support plans which identified areas of people's needs. These records were supplemented by additional information. This information ranged from people's support needs for personal care, nutrition, mobility, falls and other aspects of people's lives, information about risks and how they were managed were also included.

However in all the care files we looked at in Chelston Park there were gaps in the information or information was missing. For example in the support plan for one person the sections on oral health, foot care and mobility had not been completed. For another person who required the assistance of equipment to stand safely whilst transferring the type of belt to be used was not noted or the hoist sling size recorded. For another person where the care record stated "encourage snacks" there was no evidence of the person having received snacks in the recording made in their daily notes. Where information was missing we spoke with the senior nurse and the care workers to clarify that they knew about the equipment required, the oral care needed and the dietary needs of a person. They were able to tell us the specific needs of each person. This meant that although current staff knew about the care needs of the people they cared for, new or temporary care workers would not have access to adequate information about the people they supported.

In the records of one person we looked at we saw where the person was diagnosed with dementia and lacked capacity to make decisions for themselves. A Mental Capacity Act (MCA) assessment had been completed and best interest assessments had also been completed for specific circumstances. However for another person with the same diagnosis the person's capacity had not been assessed or recorded. The two other files we looked at had not included capacity assessments to indicate whether they had capacity or not. We discussed these findings with the senior nurse who told us they would arrange for reviews of the record keeping.

Where a person had swallowing problems following a stroke this had been recorded and a speech and language therapist had been involved advising about dietary needs. However as the persons condition changed and their ability to eat different consistencies of food improved this had not been recorded in the care file. The care workers we spoke with were able to describe the eating abilities of the person and knew what they could or could not manage to eat in puree or other forms. This meant that although current staff knew about the dietary needs of the people they cared for, there was a risk that new or temporary care workers would not have access to adequate information how to support people at meal times.

The majority of entries made in people's daily notes by care workers did not state the times that events took place and did not fully reflect the activities or daily occurrences they participated in. Where entries were made they were not recorded in a person centred way and were largely task focussed. For example one person was described as having had a "normal settled night", whilst another person had "appeared sleepy". There was no description of what a "normal" night was or why the person was appearing "sleepy". People's names were not often used in the daily records. This showed records did not reflect the actual delivery of support for people.

We looked at seven care records in Chelston Gardens. Records were comprehensive, containing detailed pre assessment forms and 'This is me' documentation. Care plans were updated monthly and had been updated following changes in people's conditions. Daily records were completed but did not always contain detail of activities undertaken or specific care such as results from checking the feet of a person who was diabetic.

Other records relevant to the management of the services were accurate and fit for purpose. We heard how regular audits of the service were carried out by an internal auditor, where actions were required we heard about plans to resolve issues that were raised during this process. Copies of important documents were kept in the service for example the organisations current insurance certificate. There were records to show equipment such as fire extinguishers, fire alarm testing and prevention of Legionella were all up to date.

Other records about the running of the home were held securely in the providers' office or one the computer system. For example records relating to staff; finance or contracts were held in locked drawers or cabinets. The computer systems in the home had restricted access. This meant people could be assured that the records for the management and administration of the service were held securely and only used by appropriate staff.

We found all records were kept securely and could be located promptly when needed. Each person had their own records kept in the medication room which care workers could access; the doors had locks so that only staff or people invited in could access the records. Whilst this provided secure storage of records it also allowed unauthorised staff into the medication room which is contrary to the guidance for the Handling of Medicines in Social Care. The guidance states "The designated place for storing medicines must be secure and only those staff who handle medicines should have access." This meant care workers had access to an area which should be restricted to them.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: People were not fully protected from the risk of infection because appropriate guidance had not always been followed. Some parts of the home were not completely clean or hygienic. Regulation 12 (2)(c)(i)(ii)(iii)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because their care records were not accurate or maintained. Regulation 20 (1)(a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008

This section is primarily information for the provider

(Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 28 January 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk